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Trauma-Informed Telehealth in the COVID-19 Era and Beyond

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Background: The Veterans Health Administration (VHA) entered the COVID-19 pandemic crisis with an existing and robust telehealth program, but it still faces a fundamental paradigm shift as most routine outpatient in-person care was converted to telehealth visits. Veterans are a highly trauma-exposed population, and VHA has long offered effective telemental health services. Natural disasters and pandemics like COVID-19 are known to be traumatic. Those with preexisting trauma exposure and mental health conditions are often at greater risk than the general population for long-term adverse health sequelae. Application of trauma-informed principles to telehealth care is critical and timely.

Observations: Trauma-focused care (including telemental health) refers to evidence-based treatment models that directly facilitate recovery from trauma-related conditions like posttraumatic stress disorder. Despite the widespread availability of trauma-focused treatment in VHA, not all veterans chose to engage in it. In contrast, trauma-informed care (TIC) is a global, "universal precautions" approach to providing strengths-based, collaborative quality medical care in any discipline or location. In this article the authors, all primary care and mental health clinicians at VHA, advocate for the application of the 6 Substance Abuse and Mental Health Services Administration principles of trauma-informed care to telehealth. Using examples from telehealth research conducted in trauma-exposed patient populations, we illustrate the characteristics of telehealth that are well suited to delivery of trauma-informed care and suggest readily applicable strategies that can be used across disciplines including primary care and medical/surgical specialties. A primary care patient case scenario is included to illustrate how telehealth visits can be trauma-informed.

Conclusions: Telehealth expansion has occurred nationally out of necessity during the COVID-19 pandemic. Trauma-informed virtual care has the potential to ensure and even expand continuity of medical care by fostering safe and collaborative interactions between patients and the health care team.

COVID-19 has created stressors that are unprecedented in our modern era, prompting health care systems to adapt rapidly. Demand for telehealth has skyrocketed, and clinicians, many of whom had planned to adopt virtual practices in the future, have been pressured to do so immediately.[1] In March 2020, the Centers for Medicare and Medicaid Services (CMS) expanded telehealth services, removing many barriers to virtual care.[2] Similar remedy was not necessary for the Veterans Health Administration (VHA) which reported more than 2.6 million episodes of telehealth care in 2019.[3] By the time the pandemic was underway in the US, use of telehealth was widespread across the agency. In late March 2020, VHA released a COVID-19 Response Plan, in which telehealth played a critical role in safe, uninterrupted delivery of services.[4] While telehealth has been widely used in VHA, the call for replacement of most in-person outpatient visits with telehealth visits was a fundamental paradigm shift for many patients and clinicians.[4]

The Coronavirus Aid, Relief, and Economic Security (CARES) Act (HR 748) gave the US Department of Veterans Affairs (VA) funding to expand coronavirus-related telehealth services, including the purchase of mobile devices and broadband expansion. CARES authorized the agency to expand telemental health services, enter into short-term agreements with telecommunications companies to provide temporary broadband services to veterans, temporarily waived an in-person home visit requirement (accepting video and phone calls as an alternative), and provided means to make telehealth available for homeless veterans and case managers through the HUD-VASH (US Department of Housing and Urban Development-VA Supportive Housing) program.

VHA is a national telehealth exemplar, initiating telehealth by use of closed-circuit televisions as early as 1968, and continuing to expand through 2017 with the implementation of the Veterans Video Connect (VVC) platform.[5] VVC has enabled veterans to participate in virtual visits from distant locations, including their homes. VVC was used successfully during hurricanes Sandy, Harvey, Irma, and Maria and is being widely deployed in the current crisis.[6-8]

While telehealth can take many forms, the current discussion will focus on live (synchronous) videoconferencing: a 2-way audiovisual link between a patient and clinician, such as VVC, which enables patients to maintain a safe and social distance from others while connecting with the health care team and receiving urgent as well as ongoing medical care for both new and established conditions.[9] VHA has developed multiple training resources for use of VVC across many settings, including primary care, mental health, and specialties. In this review, we will make the novel case for applying a trauma-informed lens to telehealth care across VHA and beyond to other health care systems.

Trauma-Informed Care

Although our current focus is rightly on mitigating the health effects of a pandemic, we must recognize that stressful phenomena like COVID-19 occur against a backdrop of widespread physical, sexual, psychological, and racial trauma in our communities. The Substance Abuse and Mental Health Services Administration (SAMHSA) describes trauma as resulting from "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."[10] Trauma exposure is both ubiquitous worldwide and inequitably distributed, with vulnerable populations disproportionately impacted.[11,12]

Veterans as a population are often highly trauma exposed, and while VHA routinely screens for experiences of trauma, such as military sexual trauma (MST) and intimate partner violence (IPV), and potential mental health sequelae of trauma, including posttraumatic stress disorder (PTSD) and suicidality, veterans may experience other forms of trauma or be unwilling or unable to talk about past exposures.[13] One common example is that of adverse childhood experiences (ACEs), which include household dysfunction, neglect, and physical and sexual abuse before the age of 18 years.[14] ACEs have been associated with a wide range of risk behaviors and poor health outcomes in adulthood.[14] In population-based data, both male and female veterans have reported higher ACE scores.[15] In addition, ACE scores are higher overall for those serving in the all-volunteer era (after July 1, 1973).[16] Because trauma may be unseen, unmeasured,

and unnamed, it is important to deliver all medical care with sensitivity to its potential presence.

It is important to distinguish the concept of trauma-informed care (TIC) from trauma-focused services. Trauma-focused or trauma-specific treatment refers to evidence-based and best practice treatment models that have been proven to facilitate recovery from problems resulting from the experience of trauma, such as PTSD.[17] These treatments directly address the emotional, behavioral, and physiologic impact of trauma on an individual's life and facilitate improvement in related symptoms and functioning: They are designed to treat the consequences of trauma. VHA offers a wide range of trauma-specific treatments, and considerable experience in delivering evidence-based trauma-focused treatment through telehealth exists.[18,19] Given the range of possible responses to the experience of trauma, not all veterans with trauma histories need to, chose to, or feel ready to access trauma-specific treatments.[20]

In contrast, TIC is a global, universal precautions approach to providing quality care that can be applied to all aspects of health care and to all patients.[21] TIC is a strengths-based service delivery framework that is grounded in an understanding of, and responsiveness to, the disempowering impact of experiencing trauma. It seeks to maximize physical, psychological, and emotional safety in all health care encounters, not just those that are specifically trauma-focused, and creates opportunities to rebuild a sense of control and empowerment while fostering healing through safe and collaborative patient-clinician relationships.[22] TIC is not accomplished through any single technique or checklist but through continuous appraisal of approaches to care delivery. SAMHSA has elucidated 6 fundamental principles of TIC: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment; voice and choice; and sensitivity to cultural, historical, and gender issues.[10]

TIC is based on the understanding that often traditional service delivery models of care may trigger, silence, or disempower survivors of trauma, exacerbating physical and mental health symptoms and potentially increasing disengagement from care and poorer outcomes.[23] Currier and colleagues aptly noted, "TIC assumes that trustworthiness is not something that an organization creates in a veteran client, but something that he or she will freely grant to an organization."[24] Given the global prevalence of trauma, its well-established and deleterious impact on lifelong health, and the potential for health care itself to be traumatizing, TIC is a fundamental construct to apply universally with any patient at any time, especially in the context of a large-scale community trauma, such as a pandemic.[12]

Trauma-Informed COVID-19 Care

Catastrophic events, such as natural disasters and pandemics, may serve as both newly traumatic and as potential triggers for survivors who have endured prior trauma.[25,26] Increases in depression, PTSD, and substance use disorder (SUD) are common sequalae, occurring during the event, the immediate aftermath, and beyond.[25,27] In 2003, quarantine contained the spread of Severe acute respiratory syndrome (SARS) but resulted in a high prevalence of psychological distress, including PTSD and depression.[27] Many veterans may have deployed in support of humanitarian assistance/disaster relief missions, which typically do not involve armed combat but may expose service members to warlike situations, including social insecurity and suffering populations.[28] COVID-19 may be reminiscent of some of these deployments as well.

The impact of the current COVID-19 pandemic on patients is pervasive. Those with preexisting financial insecurity now face additional economic hardship and health challenges, which are amplified by loneliness and loss of social support networks.[26] Widespread unemployment and closures of many businesses add to stress and may exacerbate preexisting mental and physical health concerns for many; some veterans also may be at increased risk.[29] While previous postdisaster research suggests that psychopathology in the general population will significantly remit over time, high-risk groups remain vulnerable to PTSD and bear the brunt of social and economic consequences associated with the crisis.[25] Veterans with preexisting trauma histories and mental health conditions are at increased risk for being retraumatized by the current pandemic and impacted by isolation and unplanned job or wage loss from it.[29] Compounding this, social distancing serves to protect communities but may amplify isolation and danger in abusive relationships or exacerbate underlying mental illness.[26,30]

Thus, as we expand our use of telehealth, replacing our face-to-face visits with virtual encounters, it is critical for clinicians to be mindful that the pandemic and public health responses to it may result in trauma and retraumatization for veterans and other vulnerable patients, which in turn can impact both access and response to care. The application of trauma-informed principles to our virtual encounters has the potential to mitigate some of these health impacts, increase engagement in care, and provide opportunities for protective, healing connections.

In the setting of the continued fear and uncertainty of the COVID-19 pandemic, we believe that application of a trauma-informed lens to telehealth efforts is timely. While virtual visits may seem to lack the warmth and immediacy of traditional medical encounters, accumulated experience suggests otherwise.[19] Telehealth is fundamentally more patient-focused than traditional encounters, overcomes service delivery barriers, offers a greater range of options for treatment engagement, and can enhance clinician-patient partnerships.[6,31,32] Although the rapid transition to telehealth may be challenging for those new to it, experienced clinicians and patients express high degrees of satisfaction with virtual care because direct communication is unhampered by in-office challenges and travel logistics.[33]

While it may feel daunting to integrate principles of TIC into telehealth during a crisis-driven scale-up, a growing practice and body of research can inform these efforts. To help better understand how trauma-exposed patients respond to telehealth, we reviewed findings from trauma-focused telemental health (TMH) treatment. This research demonstrates that telehealth promotes safety and collaboration —fundamental principles of TIC—that can, in turn, be applied to telehealth visits in primary care and other medical and surgical specialties. When compared with traditional in-person treatment, studies of both individual and group formats of TMH found no significant differences in satisfaction, acceptability, or outcomes (such as reduction in PTSD symptom severity scores[34]), and TMH did not impede development of rapport.[19,35]

Although counterintuitive, the virtual space created by the combined physical and psychological distance of videoconferencing has been shown to promote safety and transparency. In TMH, patients have reported greater honesty due to the protection afforded by this virtual space.[31] Engaging in telehealth visits from the comfort of one's home can feel emotionally safer than having to travel to a medical office, resulting in feeling more at ease during encounters.[31] In one TMH study, veterans with PTSD described high comfort levels and ability to let their guard down during virtual treatment.[19] Similarly, in palliative telehealth care, patients reported that clinicians successfully nurtured an experience of intimacy, expressed empathy verbally and nonverbally, and responded to the patient's unique situation and emotions.[33]

Trauma-Informed Telehealth

We have discussed how telehealth's greater flexibility may create an ideal environment in which to implement principles of TIC. It may allow increased collaboration and closeness between patients and clinicians, empowering patients to codesign their care.[31,33] The Table reviews 6 core SAMHSA principles of TIC and offers examples of their application to telehealth visits. The following case illustrates the application of trauma-informed telehealth care.

Case Presentation

S is a 45-year-old male veteran of Operation Enduring Freedom (OEF) who served as a combat medic. He has a history of osteoarthritis and PTSD related to combat experiences like caring for traumatic amputees. Before the pandemic began, he was employed as a server at a local restaurant but was laid off as the business transitioned to takeout orders only. The patient worked near a VA primary care clinic and frequently dropped by to see the staff and to pick up prescriptions. He had never agreed to video visits despite receiving encouragement from his medical team. He was reluctant to try telehealth, but he had developed a painful, itchy rash on his lower leg and was concerned about getting care.

For patients like S who may be reluctant to try telehealth, it is important to understand the cause. Potential barriers to telehealth may include lack of Internet access or familiarity with technology, discomfort with being on video, shame about the appearance of one's home, or a strong cultural preference for face-to-face medical visits. Some may miss the social support benefit of coming into a clinic, particularly in VHA, which is designed specifically for veteran patients. For these reasons it is important to offer the patient a choice and to begin with a supportive phone call that explores and strives to address the patient's concerns about videoconferencing.

The clinic nurse called S who agreed to try a VVC visit with gentle encouragement. He shared that he was embarrassed about the appearance of his apartment and fearful about pictures being recorded of his body due to "a bad experience in my past." The patient was reassured that visits are private and will not be recorded. The nurse also reminded him that he can choose the location in which the visit will take place and can turn his camera off at any time. Importantly, the nurse did not ask him to recount additional details of what happened in his past. Next, the nurse verified his location and contact information and explained why obtaining this information was necessary. Next, she asked his consent to proceed with the visit, reminding him that the visit can end at any point if he feels uncomfortable. After finishing this initial discussion, the nurse told him that his primary care physician (PCP) would join the visit and address his concerns with his leg.

S was happy to see his PCP despite his hesitations about video care. The PCP noticed that he seemed anxious and was avoiding talking about the rash. Knowing that he was anxious about this VVC visit, the PCP was careful to look directly at the camera to make eye contact and to be sure her face was well lit and not in shadows. She gave him some time to acclimate to the virtual environment and thanked him for joining the visit. Knowing that he was a combat veteran, she warned him that there have been sudden, loud construction noises outside her window. Although the PCP was pressed for time, she was aware that S may have had a previous difficult experience around images of his body or even combat-related trauma. She gently brought up the rash and asked for permission to examine it, avoiding commands or personalizing language such as "show me your leg" or "take off your pants for me."[36]After some hesitation, the patient revealed his leg that appeared to have multiple excoriations and old scars from picking. After the examination, the PCP waited until the patient's leg was fully covered before beginning a discussion of the care plan. Together they collaboratively reviewed treatments that would soothe the skin. They decided to virtually consult a social worker to obtain emergency economic assistance and to speak with the patient's care team psychologist to reduce some of the anxiety that may be leading to his leg scratching.

Case Discussion

This case illustrates the ways in which TIC can be applied to telehealth for a veteran with combat-related PTSD who may have experienced additional interpersonal trauma. It was not necessary to know more detail about the veteran's trauma history to conduct the visit in a trauma-informed manner. Connecting to patients at home while considering these principles may thus foster mutuality, mitigate retraumatization, and cultivate enhanced collaboration with health care teams in this era of social distancing.

While a virtual physical examination creates both limitations and opportunity in telehealth, patients may find the greater degree of choice over their clothing and surroundings to be empowering. Telehealth also can allow for a greater portion of time to be dedicated to quality discussion and collaborative planning, with the clinician hearing and responding to the patient's needs with reduced distraction. This may include opportunities to discuss mental health concerns openly, normalize emotional reactions, and offer connection to mental health and support services available through telehealth, including for patients who have not previously engaged in such care.

Conclusions

Telehealth expansion is occurring out of necessity in a time of crisis. While VHA is expanding its already robust telehealth program to replace some in-person visits, many other health care systems are just beginning to use telehealth. Trauma-informed virtual care during

the COVID-19 pandemic has the potential to ensure and even expand continuity of medical care, offer connection and support to trauma survivors, and enhance patient and clinician resilience in this time of need. Clinicians have a unique opportunity in this pandemic to apply TIC principles early on and to envision how telehealth may contribute to a more meaningful care experience for all and a more equitable future for those we care for.

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